APPENDIX J

CERTIFICATION FOR BLOOD GLUCOSE MONITOR

Alliant GMCF
PA/UM Department
PO Box 105329
Atlanta, GA 30346

Prior approval not required 10-01-99 for glucose monitors

Member Medicaid Number _____ Date of Birth _____

Member Full Name _____

DIAGNOSIS: _____

FOR STRIPS AND/OR LANCETS (over the maximum allowable)
How many times per day does the member need to be tested? _____
If greater than QID provide medical justification _____
What length of time should the member be tested? _____

Is the member or caregiver capable of being trained to effectively use a blood glucose monitor?
❒ YES ❒ NO

I CERTIFY THAT THIS BLOOD GLUCOSE MONITOR IS MEDICALLY NECESSARY:

Physician Signature* _____ Date _____
Physician's Printed name _____
Address _____
***Stamped signatures or dates are not acceptable**